

Miller, Paul K., Woods, Amanda L., Sloane, Charles and Booth, Lisa (2016) Obesity, heuristic reasoning and the organization of communicative embarrassment in patient-facing diagnostic radiography. In: UK Radiological Congress (UKRC), 6-8 June 2016, ACC Liverpool, UK.

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Obesity, Heuristic Reasoning and the Organization of Communicative Embarrassment in Patient-Facing Diagnostic Radiography

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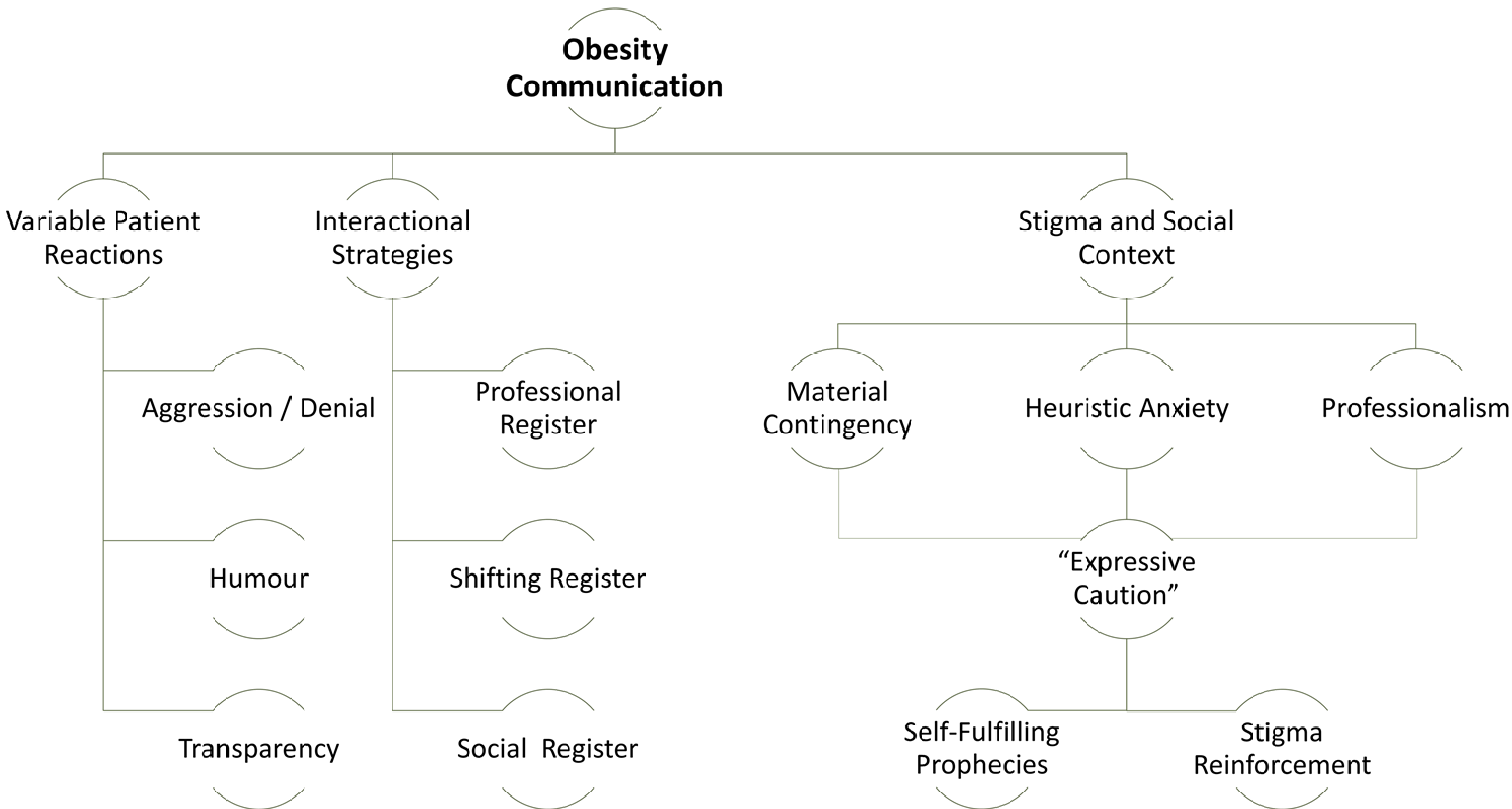
Background

The Western obesity epidemic affects all socioeconomic groups, ages and genders, but the corpus of empirical research into the practical ways in which patient obesity impacts upon the everyday practice of professional radiographers remains in a fledgling state (Woods, Miller & Sloane, 2016). In the broader healthcare sciences, an array of studies have explored professional-patient communication around a variety of nominally difficult topics, such as mental illness (Nieuwsma & Pepper, 2010), HIV (Silverman, 1997) and, indeed, obesity itself (Swift et al., 2013). In radiological fields, however, has been no research to date into the impacts of a patient’s obesity on clinical communicative dynamics.

Method

A thematic approach informed by Interpretative Phenomenological Analysis (IPA) was used to explore everyday communicative challenges faced by medical imaging professionals when interacting with bariatric patients. Employing a sample of N=8 such professionals, with 5-35 years of front-line experience, open-ended, semi structured interviews were conducted. Data were analysed in line with the standard idiographic techniques of IPA (Smith, Flowers & Larkin, 2009).

Findings



Discussion/Conclusion

1. Analysis revealed that stigma and embarrassment around a patient’s obesity was not an innate property of obesity itself, but was embedded in material clinical circumstances (Goffman, 1963), such as examination problems or inappropriate technology.
2. Participants were able to recount cases where a patient had addressed their own obesity with humour or acceptance as freely as they could recount patients who responded with denial or aggression. They were also able to recount three core communicative strategies they had used to avoid embarrassment, or pacify “difficult” situations.
3. **However**, despite (1) and (2), there prevailed an assumption that obesity was *inherently* difficult to talk about; this implies an availability heuristic (Gigerenzer, 2004), whereby negative experiences disproportionately inform assumption about “best practice”.
4. Alongside (3), participants made assumptions regarding “appropriate” professional practice that further inhibited their likelihood of talking openly (or at all) to a patient about obesity – i.e. they largely adopted a form of “expressive caution” (Silverman, 1997). Such explicitly “cautious” treatment of a potentially difficult topic has, however, been widely noted to sometimes reinforce stigmas, engendering self-fulfilling prophecies around sensitive matters in medical interaction (Miller, 2013).
5. Finally, it is noted that this assumption of the need for high levels of this expressive caution in obesity communication runs strongly counter the UK NHS “Every Contact Counts” agenda.

Refs

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